

**EXHIBIT C**

**Medical File of William David Carroll**

Covington County Sheriff

**MEDICAL SCREENING FORM**Booking Number  
200009274

Printed: Sun Nov 20, 2005

**WILLIAM DAVID CARROLL (S416882767)**

Booking Date

**NOVEMBER 19th, 2005****ADMISSION OBSERVATIONS**

Is inmate conscious?	<input checked="" type="radio"/> Y <input type="radio"/> N	Is inmate capable of responding?	<input checked="" type="radio"/> Y <input type="radio"/> N	Can inmate walk on own?	<input checked="" type="radio"/> Y <input type="radio"/> N
Any difficulty breathing?	Y <input type="radio"/> <input checked="" type="radio"/> N	Is inmate hostile/aggressive?	Y <input type="radio"/> <input checked="" type="radio"/> N	Any visible signs of trauma, bleeding, wounds or illness?	Y <input type="radio"/> <input checked="" type="radio"/> N
Did arrest result in injury?	Y <input type="radio"/> <input checked="" type="radio"/> N	Any fever, swollen lymph nodes, or jaundice?	Y <input type="radio"/> <input checked="" type="radio"/> N	Is skin in good condition and free of vermin?	Y <input type="radio"/> <input checked="" type="radio"/> N
Is inmate under obvious influence of alcohol?	Y <input type="radio"/> <input checked="" type="radio"/> N	Is inmate under obvious influence of drugs?	Y <input type="radio"/> <input checked="" type="radio"/> N	Any visible signs of alcohol or drug withdrawal symptoms?	Y <input type="radio"/> <input checked="" type="radio"/> N
Does inmate suggest risk of suicide?	Y <input type="radio"/> <input checked="" type="radio"/> N	Do you consider inmate an escape risk?	Y <input type="radio"/> <input checked="" type="radio"/> N		

Observations

**SUBJECT SEEMS TO BE IN GOOD HEALTH AT TIME OF INTAKE****INMATE QUESTIONNAIRE****HAVE YOU EVER HAD/HAVE ANY OF THE FOLLOWING ILLNESSES OR CONDITIONS?**

Hepatitis	Y <input type="radio"/> <input checked="" type="radio"/> N	Heart Disease	Y <input type="radio"/> <input checked="" type="radio"/> N	Mental/Emotional Upset	Y <input type="radio"/> <input checked="" type="radio"/> N
Tuberculosis	Y <input type="radio"/> <input checked="" type="radio"/> N	Hypertension	Y <input type="radio"/> <input checked="" type="radio"/> N	Attempted Suicide	Y <input type="radio"/> <input checked="" type="radio"/> N
Sexually Transmitted Disease	Y <input type="radio"/> <input checked="" type="radio"/> N	Epilepsy/Convulsions	Y <input type="radio"/> <input checked="" type="radio"/> N	Asthma/Emphysema	Y <input type="radio"/> <input checked="" type="radio"/> N
Ulcers	Y <input type="radio"/> <input checked="" type="radio"/> N	Hemophiliac (bleeder)	Y <input type="radio"/> <input checked="" type="radio"/> N	Cancer	Y <input type="radio"/> <input checked="" type="radio"/> N
Kidney Trouble	Y <input type="radio"/> <input checked="" type="radio"/> N	Aids/Exposed to Aids	Y <input type="radio"/> <input checked="" type="radio"/> N	Diabetes	Y <input type="radio"/> <input checked="" type="radio"/> N
DT's	Y <input type="radio"/> <input checked="" type="radio"/> N	Skin Problems	Y <input type="radio"/> <input checked="" type="radio"/> N	Use Insulin	Y <input type="radio"/> <input checked="" type="radio"/> N
Drug Addiction	Y <input type="radio"/> <input checked="" type="radio"/> N	Alcoholism	Y <input type="radio"/> <input checked="" type="radio"/> N	Mental Illness	Y <input type="radio"/> <input checked="" type="radio"/> N
Recent Head Injury	Y <input type="radio"/> <input checked="" type="radio"/> N	Coughed/Passed Blood	Y <input type="radio"/> <input checked="" type="radio"/> N	Recent Hospital Patient	Y <input type="radio"/> <input checked="" type="radio"/> N
Recent Treatment	Y <input type="radio"/> <input checked="" type="radio"/> N	Use Needles	Y <input type="radio"/> <input checked="" type="radio"/> N	False Limbs/Teeth	Y <input type="radio"/> <input checked="" type="radio"/> N
Contagious Disease	Y <input type="radio"/> <input checked="" type="radio"/> N	Pregnant/Recent Delivery	Y <input type="radio"/> <input checked="" type="radio"/> N		

Doctors Name and Address

**NONE**

Health Insurance

**NONE**

Special Diet

**NONE**

Prescriptions/Medications

**NONE**

Drug Allergies

**NONE KNOWN**

Descriptions

I have read the above carefully and have answered all questions correctly to the best of my knowledge.

Inmate's Signature \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Officers's Signature \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**CJ017 MILLER, J.D.**

Southern Health Partners, Inc.

## ADMISSION DATA / HISTORY AND PHYSICAL FORM

Exam Date: 12-17-05 S.S.# 416-88-2767 ID# 5416882767  
 Inmate Name: Carroll William David Date Booked: 11-19-2005  
 Alias: \_\_\_\_\_ County: \_\_\_\_\_  
 Address: 31867 Pigeon Creek Rd Red Level, AL 36474  
 Telephone: N/A Birthdate: 07-15-1967 Religion: Nonden.  
 Education Completed: 5th grade Special Education: \_\_\_\_\_  
 Marital Status: S M W (D) Separated Read/Write English: (YES) NO Other: \_\_\_\_\_  
 Previous Incarcerations: (Facility/Date) Walton C.T. Covington County Jail

## MEDICAL HISTORY

Notify in Emergency: Linda Bowman Sister  
 Address: 140144 Powell Rd. Andalusia AL 36420 Phone: 222-5745  
 Health Insurance: none  
 Family Physician: none  
 Past Hospitalizations (include surgeries): 1987 - hernia repair  
Georgia Hosp.  
 Head Injury with Loss of Consciousness: no Last Tetanus: 2000 Immunization: \_\_\_\_\_  
 Allergies: NKA  
 Current Medication(s): none

## MENTAL HEALTH EVALUATION

Hospitalization for Mental Health Reasons: YES (NO) If Yes, Why: \_\_\_\_\_  
 Where: \_\_\_\_\_ When: \_\_\_\_\_  
 Psychotropic Meds (Specify type and last dose): \_\_\_\_\_  
 Prior Counseling/Out-Patient Treatment for: no  
 Where: \_\_\_\_\_ When: \_\_\_\_\_  
 Have you ever attempted suicide: no How: \_\_\_\_\_ When: \_\_\_\_\_  
 Have you recently considered committing suicide? no  
 Do people consider you a violent person? no  
 Have you ever been arrested for a violent crime/sexual offense? (Specify) yes - murder 2nd. 1986  
 Street drugs: yes - meth daily 2 yrs. Smoker: yes Etoh: no  
 Inmate's Signature: William David Carroll Date: 12-17-05  
 Interviewer's Signature: Kelli Ballin LSW Date: 12-17-05  
 Witness: (if physical is refused): \_\_\_\_\_ Date: \_\_\_\_\_

Problems	Yes	No	Problems	Yes	No	Problems	Yes	No
Vision		✓	Hypertension		✓	Gonorrhea		✓
Hearing		✓	Anemia		✓	Syphilis		✓
Balance/Dizziness		✓	Blood		✓	Muscle Problem		✓
Blackouts		✓	Stomach Pain		✓	Joint Problem		✓
DT's		✓	Heartburn		✓	Arthritis		✓
Headaches		✓	Ulcer		✓	Other		✓
Seizures		✓	Nausea/Vomiting		✓	Other		✓
Nervous Disorder		✓	Gall Bladder		✓	Regular Menstrual Period		✓
Throat		✓	Liver		✓	Irregular Menstrual Period		✓
Teeth		✓	Hepatitis		✓	# of days Menstrual Period		✓
Asthma		✓	Diabetes		✓	LMP		✓
Hay Fever		✓	Kidney Disease		✓	Gravida/Para		✓
Pneumonia		✓	Bladder Infection		✓	Last Pap		✓
Tuberculosis		✓	Trouble Voiding		✓	Contraception		✓
Heart		✓	Pediculi (lice)		✓	Other		✓

**EXAM:**

Age 38 Sex M Race W Ht. 5'9 Wt. 163.5  
Pulse 50 BP 140/90 Temp. 96.4 Resp. 20

Area/Type	N	A/Comment	Area/Type	N	A/Comment
Skin: Color Condition Turgor Recent Inj.		OK	Chest (Breasts): Configuration Auscultation Respirations Cough/Sputum		OK
Head: Glasses Pupils Sclera Conjunctiva Vision		OK	Heart: Auscultation Radial pulses Apical pulse Rhythm		OK
Ears: Appearance Canals Hearing		OK	Extremities: Pulses Edema Joints		OK
Mouth: Teeth/Gums Dentures Plates Throat Tongue Tonsils		OK	Abdomen: Shape Palpation Hernia Bowel Sounds		OK
Nose		OK	Spine		OK
Neck: Veins Mobility Thyroid Carotids Lymph nodes		OK	Genital/Urinary System		OK

**LABORATORY TESTS**

	Date & Initial	Results
Was PPD planted and read timely?	12/17/05 JH	12/19/05 AC 1+3
VDRL / RPR	Ø	
Other Lab Tests needed:	Ø	
Pregnancy Test?	Ø	

**MENTAL HEALTH OBSERVATION**

	N	A/Comment
Orientation (person, place, time)		X3
General appearance (motor behavior, mannerisms) Affect (mood)		Calm/cooperative
Content of thought, history of suicide, present thoughts of suicide		OK

Physical Examiner's Signature: Keelie Hallis LPM  
Physician's Signature: 11/1/07

Date: 12-17-05  
Date:

# Tuberculosis Screening and Treatment

## What is Tuberculosis:

Tuberculosis ("TB") is a serious, infectious (transmitted through the air) disease that most commonly affects the lungs. In the lungs, the bacteria destroys elastic lung tissues and is replaced with fibrous connective tissues. The general symptoms of active TB are often subtle, unnoticeable and may include: Fatigue; Weight Loss; Fever; Chills; and Night Sweats. Symptoms of TB in the lungs may include: a persistent cough; chest pain; and coughing up blood. Although TB is preventable and can be cured with proper medication, 5% to 10% of those with active TB will die from the disease. This is usually due to patients not taking their medications correctly or improper drug treatment. TB is usually diagnosed through the use of the Mantoux tuberculin skin test. In this test, a dose of purified protein derived from the Tubercle bacilli, which is non-infectious, is injected into the upper layer of skin on the inside of the forearm. Forty-eight to 72 hours after the injection, the test site is examined. In most cases a hardened area of tissue 10 millimeters or larger is considered an indication of infection with TB, but it is not necessarily an indication of having active TB. Chest x-rays and sputum smears and cultures are used to test for active TB.

There are several high risk groups in the US that are known to have a high rate of TB. They include:

- The homeless;
- IV drug users
- Alcoholics;
- Prison inmates
- The elderly;
- Persons with HIV infections/AIDS

## Screening:

Upon consent, all new inmates who are processed into jail, without written proof of receiving TB testing in the past year, will receive purified protein derivative (PPD) during the health screening. A nurse will read the PPD forty-eight (48) to seventy-two (72) hours afterwards and document the results in the patient's medical file. The patient will be instructed during the health screening to the necessity of follow-up medical care, the results (both positive or negative) and treatment which may be necessary.

## Treatment:

During the screening, if a patient states he/she is past positive, we will not plant PPD, but will obtain a chest x-ray to see if the tuberculosis is active. When a nurse reads a positive PPD, a chest x-ray will be ordered as per physician protocol. The patient will receive information regarding the test results, symptoms of TB, proposed treatment, and follow-up care, etc.

Should the chest x-ray suggest active TB, the local Health Department, SHP Medical Team Administrator, and SHP corporate office should be notified immediately. Initiating therapy/treatment should begin under the recommendations of the local Health Department and in conjunction with the jail physician. The jail will immediately segregate the patient from general population. All people who have come in contact with the patient will have a skin test. The patient will have restricted movement and visitors in the jail, and will be required to wear a mask at all times during contact with staff and/or other persons, until subsequent tests prove no longer infectious.

All new inmates who are processed into the jail, who are on treatment and deemed not infectious will be housed in general population. If a patient is released from Jail during therapy, the local Health Department will be notified and provided with the patient's release location and/or the patient's last known address.

## Consent for Testing/Treatment:

I hereby give my consent for TB testing and/or treatment, if needed. I have read and understand the above information regarding testing and treatment procedures.

Signature: William David Carroll

Date: 12/17/05

Witness: Kelli H. Carroll, LPM

Date: 12/17/05

Confidential Medical Information

② arm



TEST TEST VENTILATION FORM

For the purpose of this test, please provide the information below. The patient must be in a state of unconsciousness for the test to be performed. The patient must be in a state of unconsciousness for the test to be performed. The patient must be in a state of unconsciousness for the test to be performed.

William David Carroll  
416-88-0767 DOB 1967-07-15  
D-Block

12-17-05

Date by Nurse

Heidi Holstein

12-19-05

Date by Nurse

Al Caruso

12-19-05

Date by Nurse

Al Caruso

## INMATE SICK CALL SLIP - MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return to the medical staff for review and review by the medical staff. The medical staff will arrange for your treatment and/or staff member. You will be charged in accordance with the medical center policy.

Date 1-4-06 Inmate's Name D-Black Cell \_\_\_\_\_ ID# 416-88-2767

Inmate's Name William David Carroll

was eating supper tonight & a piece of my tooth broke off. It broke beside where the filling is.

Just happen tonight being 1-4-06  
Inmate's Name William D. Carroll Date 1-4-06

## TO BE COMPLETED BY MEDICAL STAFF:

Temp 97' Resp 18 Pulse 78 B/P 120/72

Document your findings, Inmate's responses/actions

#18 molar broken into gumline. Some pain involved. Placed on dental list. Will RX for pain.

☒ Reviewed by: ☐ Treatment Protocols, via telephone order, via verbal order  
Reviewed by: ☐ checked, date to be seen again \_\_\_\_\_

☒ Inmate's charges through medical co-pay for this visit

Date 1/5/06

Seen by: A. Cain Jern

Medical record





## INMATE SICK CALL SLIP – MEDICAL REQUEST

**TO BE COMPLETED BY INMATE:** Please complete the top half of the Sick Call Slip and return it to the correction officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 6/12/06 Pod/Location: B-Block Cell: #14 ID# 416-88-2765

Inmate's Full Name: William David Carroll

Complaint/Problem: Tooth-ache

How long have you had this problem? about 4 days - off & on.

Inmate's Signature: William David Carroll Date: 6/12/06

**TO BE COMPLETED BY MEDICAL STAFF:**

Note Patient's Vital Signs: Temp 97.6 Resp 18 Pulse 65 B/P 154/83

Instructions/Assessment: Document your findings, Inmate's responses/actions

Address to Arch upper tooth. On  
dental list. Will Rx c ABT therapy  
and IBU

☒ Received Orders – thru Treatment Protocols; via telephone order; via verbal order

☐ Follow-Up Required? If checked, date to be seen again \_\_\_\_\_

☐ Chronic Condition

☒ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical 6/15/06 Seen by: Dr. Williams, CR

Place original form in patient's medical record.





# INMATE SICK CALL SLIP – MEDICAL REQUEST

**TO BE COMPLETED BY INMATE:** Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 6/23/06 Pod/Location: B-B/K Cell: 14 ID#: 116-SS-276

Inmate's Full Name: William David Carroll

Complaint/Problem: I still have a tooth-ache & am in  
need of something for the pain

How long have you had this problem? 15 days to date being 6-23-06

Inmate's Signature: William D. Carroll Date: 6/23/06

## TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp 97.0 Resp 20 Pulse 72 B/P 140/86

Instructions/Assessment: Document your findings, Inmate's responses/actions

Will Rx to IBU for pain. NO  
abuses noted

☒ Received Orders – thru Treatment Protocols: via telephone order; via verbal order

☐ Follow-Up Required? If checked, date to be seen again \_\_\_\_\_

☐ Chronic Condition

☒ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 6/29/06 Seen by: Dr. Williams, GR

Place original form in patient's medical record.



## INMATE SICK CALL SLIP – MEDICAL REQUEST

**TO BE COMPLETED BY INMATE:** Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 7-11-06 Pod/Location: \_\_\_\_\_ Cell: \_\_\_\_\_ ID# 416 55 2167

Inmate's Full Name: Michael David Powell

Complaint/Problem: Stomach Pain

How long have you had this problem? 5-6 days

Inmate's Signature: Michael David Powell Date: 7-11-06

### TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp 97.0 Resp 20 Pulse 61 BP 157/94

Instructions/Assessment: Document your findings. Inmate's responses/actions \_\_\_\_\_

(R) U teeth (gums) red and swollen.  
Will Rx for Abscess and pain

- ☒ Received Orders – thru Treatment Protocols: via telephone order: via verbal order  
☐ Follow-Up Required? If checked, date to be seen again: \_\_\_\_\_  
☐ Chronic Condition  
☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 7/5/06 Seen by: J. Williams, MD

Place original form in patient's medical record.



# INMATE SICK CALL SLIP - MEDICAL REQUEST

**TO BE COMPLETED BY INMATE:** Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 7-13-06 Pod/Location B-BIK Cell 14 ID# 1

Inmate's Full Name: William David Carroll

Complaint/Problem: On going tooth ache

How long have you had this problem? 31 + days

Inmate's Signature: William D. Carroll Date: 7-13-06

## TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp 98.0 Resp 20 Pulse 78 BP 134/80

Instructions/Assessment: Document your findings, Inmate's responses/actions

C/O toothache. Will Rx for pain.  
No S/S of infection noted. Will  
Rx c paracetamol d/t C/O stomach  
upset.

- ☒ Received Orders – thru Treatment Protocols: via telephone order: via verbal order  
☐ Follow-Up Required? If checked, date to be seen again \_\_\_\_\_  
☐ Chronic Condition  
☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 7/14/06 Seen by: J.D. Williams, MD

Place original form in patient's medical record



# INMATE SICK CALL SLIP – MEDICAL REQUEST

**TO BE COMPLETED BY INMATE:** Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 7-23-06 Pod/Location: B-BK Cell: 14 ID# \_\_\_\_\_

Inmate's Full Name: William David Carroll

Complaint/Problem: Tooth swollen again, tooth-like

How long have you had this problem? Since 12th Aug 2006

Inmate's Signature: William D. Carroll Date: 7-23-06

## TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp 91.5 Resp \_\_\_\_\_ Pulse 69 B/P 142/93

Instructions/Assessment: Document your findings, Inmate's responses/actions (R) 1st

made with gum nodules, 2 exudate.  
2 pus pockets noted. Swath clean.  
Once again I'm remains on dental  
list + chooses to have analgesic  
provided by medical. & lymph node swelling.

☒ Received Orders – thru Treatment Protocols; via telephone order; via verbal order

☐ Follow-Up Required? If checked, date to be seen again \_\_\_\_\_

☐ Chronic Condition

☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 7/24/06 Seen by: A. Cain Jr

Place original form in patient's medical record.

## Physician's Orders

Inmate Name:

SSN:

DOB:

Allergies:

C. Wilmington

C. County

Inmate

Date:

1-5-06

IBU 800mg BID x  
7 days (toothache)

P.P. Dr. McWhorter / P. Williams

Date:

6/15/06

Amoxil 500mg Bid x 7 days

IBU 600mg Bid x 7 days

P.P. Dr. McWhorter / P. Williams

Date:

6/27/06

IBU 600mg Bid x 7

days

P.P. Dr. McWhorter / P. Williams

Date:

7/14/06

IBU 600mg Bid x  
7 days

P.P. Dr. McWhorter / P. Williams

Date:

7/18/06

Percocet i. Bid x 7

days

P.P. Dr. McWhorter / P. Williams

Date:

7-24-06

Percocet i. BID

x 7 days

P.P. Dr. McWhorter / P. Williams

Date:

7/5/06

Amoxil 500mg i. Bid x 7 days

IBU 600mg i. Bid x 7 days

P.P. Dr. McWhorter / P. Williams

## PROGRESS NOTES

Criminal William David Williams

B

Date

Notes Should Be Signed by Physician

6/15/06 I/M seen in medical c CPO toothache. Saw 1 broken broken off @ gumline. Saw swelling c/s of infection. Med. JBT & IBU for pain. Will charged for I/M to have family bring in 1 month supply to help I/M c problem of grinding teeth. J. Williams, MD

6/17/06 I/M left message on I/M's sister's answering machine @ home and on cell phone for I/M requesting a month supply. J. Williams, MD

6/27/06 I/M seen in sickle call c CPO toothache. No abscess noted. Rx for pain. Charged for family to bring in IBU for I/M. J. Williams, MD

7/6/06 I/M approached nurse on pill call - wants IBU left to officers to dispense to pump during med. as well as his BID dosing. Explained to I/M that CO's could not dispense it & pill call was BID but he could buy IBU from store call to have on hand. J. Williams, MD

7/11/06 I/M c pill call. JOK made & when he walked away he spit pills in mouth. & went back to cell. CO's notified & J.D. St. James present. J. Williams, MD



## PROGRESS NOTES

Cannon William David M. Whorter

B

Date

Notes Should Be Signed by Physician

7/14/06 I/M continues to refuse to order pain  
meds off state care. I/M will not  
7/14/06 I/M called for pill call. Apparent  
to be profiting, plexiglass in  
mouth. Requested to do mouth  
check as I/M walked off.  
He turned around opening mouth  
& had plexiglass between tongue &  
cheek. One falling to floor.  
Officer Vigor to nurse. — C. Camp



## MEDICATION ADMINISTRATION RECORD

## MEDICATIONS

## HOURS

1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12

IBU (Toothache) F ——— ~~up 1000mg 4 times a day~~

BDX (Toothache) F ——— ~~up 1000mg 4 times a day~~

1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4 5 6 7 8 9 10 11 12

ARTING FOR 1-5-06 THROUGH 1-31-06

Physician McWister Telephone No. \_\_\_\_\_ Medical Record No. \_\_\_\_\_

Physician NADA Alt. Telephone \_\_\_\_\_

Physician \_\_\_\_\_ Ref. and/or Pot. \_\_\_\_\_

Medicaid Number \_\_\_\_\_ Medicare Number SS# Approved By Doctor \_\_\_\_\_

Physician Carroll, William Paul M D

Physician \_\_\_\_\_ Date \_\_\_\_\_

## MEDICATION ADMINISTRATION RECORD

MEDICATIONS

HOUR

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

IBU 800mg  
BID x 30 daysA. G. M. D.  
P. D. M. D.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

STARTING FOR

2/1/06

THROUGH

2/28/06

Physician

M. W. H. C. H.

Telephone No.

Medical Record No.

Physician

Alt. Telephone

ergies

NKDDH

Rehabilitative  
Potential

agnosis

Medical Number

Medical Number

Approved By Doctor:

By:  
D. S. E.

Sex

Race

Title

Date

RESIDENT

Carroll, William D. M. D.

7-15-67 M

D

Foster  
C. S. E.Foster  
C. S. E.

## MEDICATION ADMINISTRATION RECORD

## MEDICATIONS

## HOUR

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Amoxil 500 mg A  
ii Bid x 7 days P~~DO NOT WRITE~~  
~~DO NOT WRITE~~IBL 600 mg A  
Bid x 7 days P~~DO NOT WRITE~~  
~~DO NOT WRITE~~IBL 600 mg A  
Bid x 7 days PDO NOT  
WRITE  
+

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

HARTING FOR

THROUGH

Physician

Physician

leries

Telephone No.

Alt. Telephone

Representative  
Potential

Medical Record No.

agnosis

Medicaid Number

Medicaid Number

Approved By Doctor

By

Type

Date

RESIDENT

Carroll, David

9/15/06 M B

Medication	Dose	Frequency	Route	Indication
T.B. 100mg	100mg	1x	PO	
Bid x 7 days				
T.B. 100mg	100mg	1x	PO	
Bid x 7 days				
Imoxil 500mg	500mg	1x	PO	
Bid x 7 days				
T.B. 100mg	100mg	1x	PO	
Bid x 7 days				
Pericapsic Ti				
Bid x 7 days				
Pericapsic Ti BID				
x 7 days				

STARTING FOR	01/11/06	THROUGH	1/31/06	Telephone No.	Medical Record No.
Location	1166/11074			Alt. Telephone	
Physician				Rehabilitative Potential	
Diagnosis	AKDHA				

  

Resident Number	Medicare Number	Approved By Doctor	Signature	Date
1166/11074	41612767	SV	01/15/06	11/15/06
Resident Name	Resident Code	Resident Room	Resident Unit	Resident Date
1166/11074	1166/11074	1166/11074	1166/11074	1166/11074